

Retired Member's

Soc. Sec. No.:

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(Rev. 8/01)

KENTUCKY RETIREMENT SYSTEMS**APPLICATION FOR MEDICAL INSURANCE REIMBURSEMENT****1. APPLICANT'S NAME:** _____ **Soc. Sec. No.:** _____

Home Address: _____

street

city

county

state

ZIP code

Check if new address: ☐

Daytime Phone: _____ Retiree's Name (if different from applicant): _____

2. MEDICAL INSURANCE POLICY INFORMATION

Medical Insurance

Company Name: _____

Insurance

Company Address: _____

Insurance

Company Phone: _____

Policy

Number: _____

Individuals covered under this policy:

Name	SSN	Relationship	Date of Birth

3. IF MEDICAL INSURANCE COVERAGE IS THROUGH EMPLOYMENT

Total Premium Amount: \$ _____ Amount Paid by Employer \$ _____

4. PREMIUM AMOUNT PAID BY APPLICANT: \$ _____ paid every _____ (mo/mos/year)

Months of Coverage

Submitted for Reimbursement: From _____ to _____, Year _____

ATTACH COPIES OF PROOF OF INSURANCE POLICY AND PAYMENT.
SEE BACK OF FORM FOR EXAMPLES OF ACCEPTABLE DOCUMENTATION.

I certify that the above information is correct. I understand that I will not be reimbursed for medical insurance premiums for any period during which I was not eligible for participation in the reimbursement plan. I further understand that if I do receive reimbursement for premiums which were not eligible, the Kentucky Retirement Systems may recover those payments from my future retirement allowances. I also understand that the Kentucky Retirement Systems may contact the insurance company directly to verify the coverage and amount of premium.

APPLICANT'S

SIGNATURE: _____ DATE: _____

Return to: Kentucky Retirement Systems, Perimeter Park West, 1260 Louisville Road, Frankfort, KY 40601-6124

KENTUCKY RETIREMENT SYSTEMS MEDICAL INSURANCE REIMBURSEMENT PLAN

The medical insurance reimbursement plan is available to a retired member of the Kentucky Employees Retirement System, County Employees Retirement System or State Police Retirement System or beneficiary of a retired member of State Police Retirement System or of a Kentucky Employees Retirement System or County Employees Retirement System hazardous member residing in another state in any month the recipient is not eligible for:

- Coverage under the contract for medical insurance for Medicare-eligible individuals maintained by the Board of Trustees;
- In-network benefits through a health maintenance organization or preferred provider organization offered through the state group medical insurance administered by the Commonwealth of Kentucky; or
- Coverage under an indemnity plan offered to and providing the same payments for medical services to retired members residing in Kentucky.

An eligible recipient must submit to the retirement office an Application for Medical Insurance Reimbursement along with one or more of the following as proof of payment for hospital and medical insurance premiums:

- A copy of the invoice from the insurance company and copy of the receipt for payment;
- A copy of the invoice from the insurance company and copy of the front and back of the cancelled check made out to the insurance company;
- A copy of a pay stub if the pay stub clearly shows a deduction for hospital and medical insurance;
- A statement from the eligible recipient's employer listing dates and amounts of premiums deducted from wages;
- A copy of a bank statement showing deductions for hospital and medical insurance if the statement clearly indicates payment to a company that provides only hospital and medical insurance;
- A copy of a bank statement showing deductions to an insurance company along with a statement from the insurance company listing dates and amounts of premiums; or
- Other documentation which the retirement system determines is sufficient to prove payment for hospital or medical insurance.

The retirement office will reimburse eligible recipients once each calendar year quarter. Eligible recipients must submit proof of payment for hospital and medical insurance by the following dates for payment in the following month:

- By April 20, for reimbursement in May;
- By July 20, for reimbursement in August;
- By October 20, for reimbursement in November; or
- By January 20, for reimbursement in February.

The retirement system will not reimburse eligible recipients for any premiums paid in a calendar year if the Application for Medical Insurance Reimbursement and proof of payment for hospital and medical insurance premiums is received in the retirement office after March 20 of the following year.

If you have any questions, please call 800-928-4646.

NOTE: If you have more than one medical insurance policy, complete an Application for Medical Insurance Reimbursement for each policy. Additional copies of the application can be obtained from the Kentucky Retirement Systems or downloaded from the retirement system website: **www.kyret.com**.